Agency Code: _ _ _ _ _ _
Check Dist. Code _ _ _ _ _ _

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT FORM FOR JULY 2006-JUNE 2007

PERSONAL DATA PRINT CLEARLY

Name:
Address:
City **State** **Zip Code**

Home Phone: ( ) __ __ __- __ __ __ __
Work Phone: ( ) __ __ __ - __ __ __ __

Social Security Number: __ __ __ /__ __ / __ __ __ __

AGENCY CODE __ __ __ __ __ __
Check Dist. Code __ __ __ __ __ __

Pay Center:
Pay Cycle:

Date of Birth: ____/____/_____

PLEASE COMPLETE: (MARK ALL APPROPRIATE CIRCLES)

I work full-time or 50% or more of the normal week:	Pay Center	I am paid:	I am 21-Pay Faculty	Sex:	Marital Status:	
	C ○ Central Payroll	B ○ Biweekly	○ Yes	M ○ Male	S ○ Single	D ○ Divorced
	U ○ University of MD	M ○ Monthly	○ No	F ○ Female	M ○ Married	W ○ Widowed
I work_____hrs. per week	S ○ Satellite (specify: _____)					L ○ Separated

EMPLOYEE STATUS

○ Open Enrollment
○ New Employee. Entry on duty date:_____
○ Return from leave of absence/LAWP. Date:_____
○ Transfer from: _____ to _____
(Agency Code) (Agency Code)
○ Employee requesting change due to change in family status
○ Employee ineligible (e.g., change to part-time less than 50%)

Note on Retroactive Adjustments:
Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn Retroactive Adjustments are mandatory to back-date coverage to date of birth.

ENROLLMENT/CHANGE ACTION REQUESTED

○ New Enrollment (New employee/return from LAWP):
○ Change in family status (employee status A,B,C)
A ○ Add spouse or dependent because of:
○ Marriage. Date: _____
○ Birth/Adoption/Appointed Permanent Legal Guardian. Date: _____
○ Resume student status. Date:_____
○ Other: _____
B ○ Remove spouse or dependent because of:
○ Divorce/Limited Divorce. Date:_____
○ Death of: _____ Date:_____ (Include copy of death certificate)
○ Dependent no longer eligible due to overage, marriage, etc.
C ○ Other Change: _____
○ Cancel all coverage-no longer eligible for benefits
- explain why:_____

Dependent Information PLEASE PRINT - DEPENDENTS INCLUDE YOUR SPOUSE AND CHILDREN

THE FOLLOWING IS RESERVED FOR DEPENDENT INFORMATION. PLEASE MAKE ANY CHANGES TO YOUR DEPENDENT FILE BELOW. YOU MAY USE THIS SECTION FOR ADDITIONS (A), CHANGES (C) OR DELETIONS (D) TO YOUR EXISTING HEALTH BENEFITS FILE. COMPLETE ALL INFORMATION IF AN ENTRY IS MADE. PLEASE PRINT CLEARLY.

A/C/D	LAST NAME	FIRST NAME	MI	SEX	BIRTH DATE	RELATION-SHIP	SOCIAL SECURITY NO.	COVER THIS DEPENDENT FOR: HEALTH	DRUG	DENTAL

If you are adding a dependent, verification is required. Please see your Benefits Booklet for dependent documentation requirements. Dependent children over age 23 must be disabled.

ENROLLMENT FOR JULY 2006-JUNE 2007

Medical Benefits

OPTIONS
- ○ New Enrollment or Change in Plan
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel all medical benefits coverage

COVERAGE LEVEL
1 ○ Individual Only
2 ○ Individual plus one child; specify_____
3 ○ Individual plus spouse
4 ○ Individual plus two or more
5 ○ End Stage Renal (ESRD) (Complete Medicare Information below)

MEDICAL PLANS

PPO Plans:
1 ○ BC/BS PPO
2 ○ MLH Eagle PPO

POS Plans:
1 ○ Aetna POS
2 ○ BC/BS MD POS
3 ○ MD IPA Preferred POS

HMO Plans:
1 ○ BlueChoice HMO
2 ○ Kaiser HMO
3 ○ Optimum Choice HMO

If you or a dependent have Medicare, write in name, Medicare number, effective date of Medicare coverage level.
Name _____ *Medicare Number* _____ *Part A Effective Date:* ___/___/___ *Part B Effective Date:* ___/___/___

Vision benefits <u>are included</u> in all medical plans. Contact the medical plan for Vision services.

Prescription Coverage

OPTIONS
- ○ New enrollment
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
1 ○ Individual Only
2 ○ Individual plus one child; specify_____
3 ○ Individual plus spouse
4 ○ Individual plus two or more

Prescription Drug is <u>not included</u> in any medical plan. You must be enrolled in the Prescription Drug Plan if you want this benefit.

Dental Coverage

OPTIONS
- ○ New enrollment or change in plan
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
1 ○ Individual Only
2 ○ Individual plus one child; specify_____
3 ○ Individual plus spouse
4 ○ Individual plus two or more

DENTAL PLANS
Check only one dental plan:
1 ○ Dental Benefits Providers Dental HMO
2 ○ United Concordia Dental HMO
3 ○ United Concordia Dental PPO

Dental is <u>not included</u> in any medical plan. You must be enrolled in a Dental Plan if you want this benefit.

Personal Accident and Dismemberment

OPTIONS
- ○ New Enrollment or addition/removal of dependent
- ○ Change of benefit amount - make a $ selection
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
1 ○ Employee only coverage
2 ○ Family coverage

BENEFIT AMOUNT
1 ○ $100,000
2 ○ $200,000
3 ○ $300,000

Pre-Tax Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

<u>YOU MUST ENROLL IF YOU WANT A SPENDING ACCOUNT IN JULY 2006-JUNE 2007</u>

DBM USE ONLY
○ HCSA ○ DCSA

HEALTH CARE (AK)

OPTIONS
1 ○ **Enroll** in Health Care Spending Account
2 ○ **Cancel** Health Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount/**per pay check***

DAY CARE (AN)

OPTIONS
1 ○ **Enroll** in Day Care Spending Account
2 ○ **Cancel** Day Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount/**per pay check***

See Benefits Book for Minimum/Maximum amounts per pay check.
Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT TO BE DEDUCTED PER PAY CHECK IN JULY 2006-JUNE 2007.

State Life Insurance Plan

EMPLOYEE

OPTIONS

- ○ Yes, I want to enroll as a new enrollee in life insurance. Make a $ selection.
- ○ I am currently enrolled in life insurance and making a change. Make a $ selection.
- ○ No, I do not want to start life insurance for myself.
- ○ Cancel life insurance.

○ $ 10,000	○ $ 20,000	○ $ 30,000	○ $ 40,000	○ $ 50,000

STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Statement of Health for yourself.

○ $ 60,000	○ $ 110,000	○ $ 160,000	○ $ 210,000	○ $ 260,000
○ $ 70,000	○ $ 120,000	○ $ 170,000	○ $ 220,000	○ $ 270,000
○ $ 80,000	○ $ 130,000	○ $ 180,000	○ $ 230,000	○ $ 280,000
○ $ 90,000	○ $ 140,000	○ $ 190,000	○ $ 240,000	○ $ 290,000
○ $ 100,000	○ $ 150,000	○ $ 200,000	○ $ 250,000	○ $ 300,000

SPOUSE

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your spouse can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance for myself, I wish to have life insurance on my spouse. Make a $ selection.
- ○ I currently have life insurance for my spouse and am making a change. Make a $ selection.
- ○ No, I do not want to start life insurance on my spouse.
- ○ Cancel life insurance on my spouse.

○ $ 5,000	○ $ 10,000	○ $ 15,000	○ $ 20,000	○ $ 25,000

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for your spouse.

○ $ 30,000	○ $ 55,000	○ $ 80,000	○ $ 105,000	○ $ 130,000
○ $ 35,000	○ $ 60,000	○ $ 85,000	○ $ 110,000	○ $ 135,000
○ $ 40,000	○ $ 65,000	○ $ 90,000	○ $ 115,000	○ $ 140,000
○ $ 45,000	○ $ 70,000	○ $ 95,000	○ $ 120,000	○ $ 145,000
○ $ 50,000	○ $ 75,000	○ $ 100,000	○ $ 125,000	○ $ 150,000

CHILDREN

SECTION 3: CHILDREN INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your children can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance on my myself, I wish to have life insurance for my child(ren). Make a $ selection.
- ○ I currently have life insurance for my child(ren) and am making a change. Make a $ selection.
- ○ No, I do not want to start life insurance on my child(ren).
- ○ Cancel life insurance on my child(ren).

○ $ 5,000	○ $ 10,000	○ $ 15,000	○ $ 20,000	○ $ 25,000

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for each covered child.

○ $ 30,000	○ $ 55,000	○ $ 80,000	○ $ 105,000	○ $ 130,000
○ $ 35,000	○ $ 60,000	○ $ 85,000	○ $ 110,000	○ $ 135,000
○ $ 40,000	○ $ 65,000	○ $ 90,000	○ $ 115,000	○ $ 140,000
○ $ 45,000	○ $ 70,000	○ $ 95,000	○ $ 120,000	○ $ 145,000
○ $ 50,000	○ $ 75,000	○ $ 100,000	○ $ 125,000	○ $ 150,000

Employee Signature

Please enroll me for the Flexible Benefits indicated on this form. I understand the benefits and limitations provided by the various plans, and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by Section 125 of the Internal Revenue Code.**

I understand that if I have enrolled in one or both of the Pre-tax Spending Accounts, that I must file for reimbursement from those accounts by October 15, 2007 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through June 30, 2007 and can only be modified if there is a qualifying change in family status.

I understand that the Flexible Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for July 2006-June 2007. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2007. I certify that neither I nor my family members are covered under another State of Maryland employee's or retiree's membership.

I CERTIFY THAT I AND ANY DEPENDENTS LISTED FOR COVERAGE ARE ELIGIBLE FOR COVERAGE. I UNDERSTAND THAT ENROLLMENT IN BENEFITS TO WHICH I OR MY DEPENDENTS ARE NOT ENTITLED IS CONSIDERED FRAUD. **IN ALL CASES I AM RESPONSIBLE FOR THE ACCURACY OF MY BENEFITS, COVERAGE LEVELS AND DEDUCTIONS.** I FURTHER UNDERSTAND THAT IF I WILLFULLY MISREPRESENT THE ELIGIBILITY OF MYSELF OR MY DEPENDENTS ON MY HEALTH BENEFITS APPLICATION, OR FAIL TO TAKE THE NECESSARY ACTION TO REMOVE INELIGIBLE DEPENDENTS, OR IN ANY WAY OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED, MY BENEFITS WILL BE CANCELED. I MAY BE REQUIRED TO REPAY ANY CLAIMS AND INSURANCE PREMIUMS WHICH HAVE BEEN PAID INAPPROPRIATELY, I MAY FACE CHARGES FOR DISMISSAL FROM STATE SERVICE, AND I MAY FACE CRIMINAL INVESTIGATION AND PROSECUTION.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Is there any other health insurance coverage in which you, your spouse or any of your dependents are enrolled? ○ Yes ○ No

Specify Who is covered, Name of Insurance Company and Policy Number:_____

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ _____/_____/_____ (_____) _____ (_____) _____

Employee Signature | Date | Work Phone Number (Ext.) | Your Home Phone Number

Agency Signature - *Agency Must Sign Here* *FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE*

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee.

X _____ _____/_____/_____ (_____) _____ _____

Agency Benefits Coordinator | Date | Work Phone Number (Ext.) | Department